MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

October 10, 2002

Characteristics of long-term care hospitals and workplan

ISSUE: Long-term care hospitals (LTCHs) are distributed unevenly through the nation. In what settings are patients who need intensive long-term care treated where there are no LTCHs? How do Medicare's costs and beneficiaries' outcomes compare for patients in those settings and similar patients in long-term care hospitals? How do costs compare for hospitals with and without onsite LTCHs and for different types of LTCHs?

KEY POINTS: LTCHs provide intensive care to patients who have multiple co-existing conditions and need inpatient care for an extended period of time. Analysts generally have perceived LTCHs as a heterogeneous group of hospitals that have in common only an average length of stay of at least 25 days. Recent research, however, has shown that LTCHs can be characterized in two ways—by certification cohort and by care specialty.

- LTCHs can be divided into three groups based on their date of certification—old hospitals certified before October 1983, middle hospitals certified between October 1983 and September 1993, and new hospitals certified after September 1993. Research shows that certification cohorts are strongly associated with other characteristics—such as ownership, hospital affiliation, payers' shares of discharges, average length of stay, Medicare median operating costs per case, location and bed size.

- Researchers also found that most LTCHs specialize in respiratory or rehabilitation care or a combination of the two. Three LTCHs specialize in treatment of patients with mental diseases or disorders; a few more fill other specialty niches.

LTCHs appear to serve a different patient population than either skilled nursing facilities (SNFs) or inpatient rehabilitation facilities (IRFs). Patient demographics and some frequent diagnoses differ. In addition, LTCH patients receive different ancillary services and more of these services than patients in the other two settings.

For the June 2003 report, we will determine where patients who need acute long-term care are treated in areas where there are no LTCHs; compare total Medicare costs and beneficiaries' outcomes—hospital readmissions, discharge to the community without additional Medicare services and expected versus actual death rates—controlling for case mix and other factors; and compare costs for hospitals with and without onsite LTCHs and for different types of LTCHs.

ACTION: Commissioners should comment on the workplan and scope of the proposed LTCH research. Staff will use the analyses resulting from this research for a chapter in the June 2003 report.

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